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A CASE OF MULTIPLE RUPTURE OF THE EYE-BALL, WITH PARTIAL DISLOCATION OF THE LENS INTO THE ANTERIOR CHAMBER.

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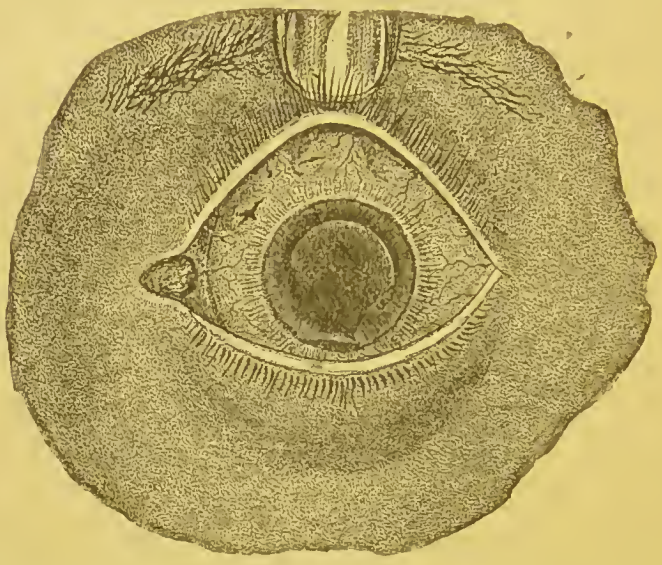
A CASE OF MULTIPLE RUPTURE OF THE EYE-BALL, WITH PARTIAL DISLOCATION OF THE LENS INTO THE ANTERIOR CHAMBER.

RECESSION OF LENS, AND RECOVERY WITH SOME VISION.

OLIVER A——, aged fifty, stockingweaver, English, was sent to my clinic at the Episcopal Hospital, March 17, 1885, suffering from the results of a severe concussion of the region of the left eye. While rapidly descending a flight of steps the previous evening, he had struck against a projecting end of a piece of board, unseen in the darkness, receiving a blow that had half stunned him by its violence.

The eyelids showed marked ecchymoses and infiltration, which had, however, been reduced by cold applications; but no wound. The conjunctival and ciliary injection was considerable, with some chemosis. In the upper inner ciliary region, 2 mm. from the apparent margin of the cornea, inspection showed a subconjunctival rupture of the sclera, of irregular stellate form, about 3 mm. in its greatest length. There was some prolapse of pigmented tissue filling it, and the conjunctiva over it was raised into a slight prominence by clear fluid. Evidences of other ruptures of the sclera on the upper aspect of the globe were faintly discerned, obscured by the conjunctival infiltration. The cornea was superficially hazy and roughened, but permitted a view of the underlying parts. A clot of blood extended obliquely down and out through the anterior chamber from the vicinity of the ciliary wound, and there was a small layer of precipitated blood at the bottom of the chamber. The iris appeared discolored and greenish, probably by reason of the blood-staining of the aqueous, and was immobile—possibly influenced by the atropia-solution which had been used some hours before. The pupil seemed

larger above and the upper half of the lens projected through it into the anterior chamber, the lower half being in normal position and its zonule probably unruptured. The exact position of most of the lower pupillary margin was hidden by the blood-clot. Vision was reduced to the counting of fingers



at one foot, and the nasal field seemed lost. The ophthalmoscope showed some faint scattered opacities in the lens and only a smoky red reflex from the fundus. The tension was subnormal, and the ball tender to the touch; pain had been severe, preventing sleep, and was still considerable.

The serious nature of the injury being explained to him, the extraction of the dislocated lens was advised. He asked for delay as the vision seemed to be increasing, probably from subsidence of the extravasations; so he was admitted to the House—rest in bed, a purgative, the free use of atropine and leeching were ordered, with iced compresses if the pain should increase.

Comparative comfort followed, and no change was noted, until two days later my colleague, Dr. Heyl, examining him with reference to the advisability of extraction, found no trace of the forward dislocation of the lens. The following day I found the anterior chamber of nearly normal depth and almost free of blood—the iris slightly tremulous, immobile, but of nearly the same color as its fellow—the pupil large medium,

vertically oval and slightly irregular. The lens showed the same scattered opacities as before, and seemed inclined to fall a little backward; but its margin could nowhere be seen, and the fundus was still hidden by the clouds in the vitreous. Vision had improved and the field seemed entire. The edges of the scleral rupture in the ciliary region were in good apposition, as were those of a second tear, higher up and about 6 mm. from the limbus; both showed pigmented tissue within their lips, but there was no hernial protrusion. A third rupture near the equator of the globe and a little external to the vertical meridian was now readily distinguished; it gaped somewhat and the conjunctiva above it was lifted in a clear circumscribed prominence by an elastic material reducible by pressure, doubtless a hernia of vitreous. Rest in bed, with atropia and a light compress bandage, was continued. He was allowed to go home after four weeks; and although unable for some weeks to occupy himself actively without bringing on pain, he was fairly comfortable with a light compress, and improvement, if slow and fluctuating, still advanced.

He returned to his knitting-work about two months after the injury, and a month later presented himself for examination with the eye quiet and free from pain, the ruptures healed and almost invisible, the pupil small medium, vertically oval, but fairly active. Vision $\frac{5}{10}$ with Burchardt's dots, and the field entire. The opacities in the lens were little if at all denser, though apparently more general; the vitreous was full of dark floating shreds, and no details of the fundus were discernible.

The lens has since become rather more moveable, falling lower and further backward than ever before, with slight increase in its opacity, and he has had attacks of pain and dim vision, apparently related to returns of malarial trouble. Vision is variable, but generally about $\frac{1}{10}$ on the metric card. The uninjured eye has remained comfortable, and with no trace of sympathetic involvement.

The principal interest of the case seems to be the spontaneous recession of a lens half dislocated into the anterior chamber.